NC DMA Hospice Reporting

Recipient Information **DMA-0004**

1. Recipient Last Name:_____ 2. First Name:_____
3. Recipient ID #_____ 4. Recipient Date of Birth:_____ 5. Recipient Gender:_____
6. Is the recipient pending eligibility? ☐ *(If checked, complete fields below)*
7. Recipient SSN: _____ Recipient County: _____

Diagnosis Information

	Diagnosis (code AND description)	Date of Onset	Primary (✓)
1			
2			
3			
4			
5			

Payer Information

8. Is this a Medicaid or Health Choice Request? Medicaid: ☐ Health Choice: ☐

Provider Information

7. Requesting Provider #:_____NPI: ☐ Atypical: ☐ 8. Taxonomy: _____
9. Address: _____ 10. Nine Digit Zip Code: _____
Name of Submitter:_____ Phone #:_____ Ext:_____

Service Information

11. Initial submission? ☐ OR Subsequent reporting? ☐
12. Effective Begin Date: _____ 13. Effective End Date:_____

Additional Information

Requesting Provider's Signature:_____ Date:_____

Fax this form to CSC at: (855) 710-1964

Instructions for completing this form can be found at http://www.NCTracks.com/PAformhelp